STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155353	A. BUILDING 00 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT GREENSBURG	1620 N LINCOLN ST GREENSBURG, IN47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00090957. Complaint IN00090957 - Substantiated - No deficiencies related to the allegations are cited. Survey dates: June 20, 21, 22, and 23, 2011 Facility number: 000244 Provider number: 155353 AIM number: 100288790 Survey team: Janie Faulkner, RN-TC Penny Marlatt, RN Diana Sidell, RN (6/22,6/23, 2011) Census bed type: SNF/NF 29 Total 29 Census Payor type: Medicare 1 Medicaid 24 Other 4 Total 29	F0000	**This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Greensburg desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on July 23, 2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 28, 2011 by Bev Faulkner, RN			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure follow-up with the primary physician on the psychologist's recommendation to increase a resident's antidepressant medication. This affected 1 of 7 residents reviewed for psychoactive medications in a sample of 10. (Resident #10) Findings include: The record review of Resident #10 on 6/23/2011 at 8:30 a.m., indicated the resident was admitted with, but not limited to the following diagnoses: Diabetes mellitus, depression, anxiety, coronary artery disease, and cerebrovascular accident with hemiparesis. The resident had a current order for Lexapro 10 mg daily at bedtime. Review of Psychologist's "FAX TRANSMITTAL SHEET," dated 2/15/11, indicated his recommendation to increase	F0250	**F 250 Social Services It is the policy of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On June 23, 2011 resident #10's attending physician was notified and updated on the Psychologist recommendation of June 15, 2011 to increase Lexapro to 20 mg every day. On June 23, 2011 resident # 10's attending physician gave new orders to increase Lexapro to 20mg by mouth every day for depression. Resident #10's family was notified of the new order and resident # 10's care plan was reviewed and updated as needed. 2.How other residents having the potential**	07/23/2011

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	Resident #10's Lexapro to 20 mg every day. "CURRENT STATUS OF CONDITION:" indicated Resident #10 with increasing depression, social isolation, and increased agitation. This fax transmittal sheet had "Agree _ _ _ (X) Disagree_ _ _ (X) _____ Date Attending Physician" The Transaction Report indicated the fax was transmitted to Resident #10's primary physician on 2/16/2011 at 12:26 P.M. A social services progress note, dated 2/16/11, included "Resident was seen by name[Psychologist's name] on 2/15/11 his recommendations were to increase Lexapro to 20 mg, waiting for [name of attending MD] response." During an interview with the SSD[Social Services Director] on 6/23/2011 at 11:40 a.m., the SSD stated, "I make a copy of [Psychologist's name]'s recommendations and fax to MD [Medical Doctor], then I talk with the nurse to have her watch for a reply from the MD and I follow-up if the MD doesn't reply." Interview with employee #5/LPN on 6/23/2011 at 1:15 p.m., regarding the process for follow-up with primary physician on the psychologist's		**to be affected by the same practice will be identified and what corrective action(s) will be taken? Every resident residing in the facility shall have their medical record audited to ensure all recommendations, including psychologist recommendations have been addressed by the attending physician. If any resident(s) are identified as having outstanding recommendation, including psychologist recommendations that have not been communicated and addressed by the attending physician, the Director of Nursing or designee will notify the attending physician immediately and document in the resident's medical record. 3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Recommendations from consultants, including psychologist, will be given to nursing and nursing will notify the resident's attending physician of recommendations. These recommendations will be faxed to the attending physician by nursing. Return fax is expected within 24 hours; after 24 hours, if no fax/phone is received, the**	

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	recommendations. She replied, "Social Services Director faxes psych recommendations and nursing writes telephone order and sends to pharmacy once doctor agrees with medication recommendations." "Sometimes the doctor takes a long time to reply." "We try not to call, but let the doctor reply to the fax." Recommendations were made on 2/15/2011 with the original fax 2/16/2011. Employee #5/LPN stated, "I guess I better call the office." Employee #5/LPN received a fax from the resident's primary care physician, dated 6/23/2011 at 1:31 p.m., agreeing to increase Resident #10's Lexapro per the Psychologist recommendations on 2/15/2011. The attending physician signed and dated agreement as, "2/16/11." 3.1-34(a)		**facility will contact the attending physician by phone. As a reminder to nursing for follow up, the original request will be maintained with the 24 hour report sheet until the request is answered by the physician. The Director of Nursing will inservice licensed nurses on this policy on July 15, 2011. At least 5 days per week, the DON or designee will review the 24 hour report and focus charting for any outstanding recommendations that have not been addressed by the physician. The DON or designee will document findings on QA Audit form F-250, 5 days per week. If the DON identifies a transmittal on the 24 hour report that the attending physician has not addressed within 24 hours, she will immediately ensure the attending physician is notified. Once the attending physician has been notified, the DON will retrain the staff member(s) involved. In addition, progressive disciplinary action will be taken for continued noncompliance. . This process will continue indefinitely and on an ongoing basis. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? While the process**	

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			of the DON reviewing the 24 hour reports, focus charting and faxes to the physician at least 5 days per week is ongoing, the documentation of the reviews will be done through the next 30 days. Once that time frame is completed, the QA &A committee will determine the continued frequency of the review documentation. The DON will bring the results of the QA audit to the interdisciplinary team meeting 5 days per week, the weekly Standard of Care meeting, the monthly QA&A meeting and to the quarterly QA&A meeting that is attended by the medical director for review and recommendations. Date of compliance July 23, 2011.	
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure routine chlorine testing was properly conducted on the dietary area dishwasher, using the numeric values provided on the test strip package. This deficient practice has the potential to adversely affect 29 of 29 residents who receive food or drink from the dietary department.	F0371	**F 371 Sanitary Conditions** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Dietary Manager performed the chlorine testing on the dish machine at the time of the survey to assure proper sanitation of dishware and equipment. The dish machine was	07/23/2011

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	Findings include: During an observation of the operation of the dishmachine on 6-22-11 at 9:40 a.m., Dietary Staff #1 demonstrated the conducting of the chlorine test. Upon completion of the test, she indicated the results were "75" as the color was between the package indicators of 50 and 100 ppm (parts per million). The package was labeled as "pHyrion Mico chlorine" and indicated the possible choices for selection, based on the color result of the test as 10, 50, 100, and 200. Dietary staff #1 recorded the result as "75" on a log titled, "Test for Low Temperature Dishmachine." The instructions for this document indicated,"Use litmus test paper to check chlorine level daily during each meal. Chlorine should be greater than 50 ppm and less than 100 ppm. Document findings of ppm on the top of box..." Review of the monthly logs for chlorine testing indicated for the month of May 2011, values varied between 110 and 120 for the breakfast meal; between 120 and 130 for the lunch meal and between 100 and 120 for the dinner meal. For the month of June 2011, values varied		noted to be functioning at the proper levels. Per facility policy and manufactures recommendations the chlorine residual level of low temperature dish machines must be greater than or equal to 50 ppm and less than or equal to 100ppm. During survey when staff performed the test for the surveyor the facility staff member indicated the ppm at "75" as it was between 50 ppm-100 ppm. 2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? The facility wishes to point out that there has been no actual resident harm as a result of this practice. During the months of April, May and June, 2 2011 no residents were identified as reporting or experiencing signs or symptoms of foodborne illnesses as a result of biological contamination, chemical contamination or physical contamination. The facility wishes to further point out that the situations occurred only occasionally. The dish machine chlorine is checked by Gordon's F ood Service representative on a monthly basis. It was checked and serviced on April 7, 2001, May 3, 2011 and June 22, 2011.	

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	between 75 and 120 for the breakfast meal; between 20 and 120 for the lunch meal and between 80 and 120 for the dinner meal. In interview with the Dietary Manager on 6-22-11 at 2:50 p.m., she indicated she had began earlier this date to inservice all of the dietary staff in regard to properly conducting the chlorine test on the dishmachine. She provided a copy of her inservice from earlier that date. The inservice information indicated, "Chlorine should be greater than 50 ppm and less than 100 ppm...you should never put a number like 88 or 97. It should be 50, 75 or 100. You have to have it read like the chlorine strips..." 3.1-21(i)(2)		During the survey all dietary staff were inserviced by the Dietary Manager. All dietary staff shall be re-inserviced by the Registered Dietitian on July 8, 2011. The inservice shall include chlorine monitoring and return demonstration by all dietary personnel , and corrective action to be taken in the event the chlorine monitoring is less than 50 ppm or greater than 100 ppm. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As stated above, all dietary staff were inserviced by the Dietary Manager during the survey. All dietary staff shall be re-inserviced by the Registered Dietician on July 8, 2011. The inservice shall include chlorine monitoring and return demonstration by all dietary personnel and corrective action to be taken in the event the chlorine monitoring is less than 50 ppm or greater than 100 ppm. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Dietary Manager or designee will review chlorine monitoring logs for the dish machine at least 5 days per week. Copies of the completed logs shall be submitted to the facility	

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			Administrator for review on a weekly basis for the next 30 days. The Registered Dietitian will review the chlorine logs for accuracy at each visit for three (3) months and monthly thereafter. Findings will be documented on the consultant report to the Administrator and Dietary Manager. **While the process of the Dietary Manager or designee reviewing the chlorine monitoring logs is ongoing, weekly review of chlorine monitoring logs shall be done through the next 30 days.** **Once that time frame is completed, the QA &A committee will determine the continued frequency of the Administrator's weekly review of the chlorine monitoring logs.** **The Dietary Manager will bring the results of the chlorine monitoring logs to the interdisciplinary team meeting 5 days per week, the weekly Standard of Care meeting, the monthly QA&A meeting and to the quarterly QA&A meeting that is attended by the medical director for review and recommendations.** Date of compliance: July 23, 2011.	

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F0385 SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on record review and interview, the facility failed to ensure the resident's primary care physician responded in a timely manner to the psychologist's recommendation to increase the resident's antidepressant medication. This affected 1 of 7 residents reviewed for psychoactive medications in a sample of 10. (Resident #10) Findings include: The record review of Resident #10 on 6/23/2011 at 8:30 a.m., indicated the resident was admitted with, but not limited to the following diagnoses: Diabetes mellitus, depression, anxiety, coronary artery disease, and	F0385	**F 385 Residents Care Supervised by a Physician** **It is the policy of this facility that a physician personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.** **The facility must ensure that the medical care of each resident is supervised by a physician, and another physician supervises the medical care of the residents when their attending**	07/23/2011

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	cerebrovascular accident with hemiparesis. The resident had a current order for Lexapro 10 mg daily at bedtime. A social services progress note, dated 2/16/11,"Resident was seen by [Psychologist's name] on 2/15/11 his recommendations were to increase Lexapro to 20 mg, waiting for [name of attending MD] response." During an interview with the SSD[Social Services Director] on 6/23/2011 at 11:40 a.m., the SSD stated, "I make a copy of [Psychologist's name] recommendations and fax to the MD[Medical Doctor], then I talk with the nurse to have her watch for a reply from MD and I follow-up if MD doesn't reply." Review of Psychologist's "FAX TRANSMITTAL SHEET," dated 2/15/11, indicated his recommendation to increase Resident #10's Lexapro to 20 mg every day. "CURRENT STATUS OF CONDITION:" indicated Resident #10 with increasing depression, social isolation, and increased agitation. This fax transmittal sheet had "Agree _ _ _ (X) Disagree_ _ _ (X) _____ _____ Date Attending Physician."		**physician is unavailable.** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **On June 23, 2011 resident #10's attending physician was notified and updated on the Psychologist recommendation of June 15, 2011 to increase Lexapro to 20 mg every day. Resident # 10's attending physician gave new orders to increase Lexapro to 20mg by mouth every day for depression. Resident #10's family was notified of the new order and resident # 10' s care plan was reviewed and updated as needed.** **2.How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?** **Every resident residing in the facility shall have their medical record audited to ensure all recommendations, including psychologist recommendations have been addressed by the attending physician.** **If any resident(s) are identified as having outstanding recommendations, including psychologist recommendation that have not been communicated and addressed by the attending physician, the Director of Nursing or designee will notify the**	

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	The Transaction Report indicated the fax was transmitted to Resident #10's primary physician on 2/16/2011 at 12:26 P.M. Interview with employee #5/LPN on 6/23/2011 at 1:15 p.m., regarding the process for follow-up with the primary physician on the psychologist's recommendations. She replied, "Social Services Director faxes psych recommendations and nursing writes a telephone order and sends to pharmacy once doctor agrees with medication recommendations." "Sometimes the doctor takes a long time to reply." "We try not to call, but let the doctor reply to the fax." Recommendations were made on 2/15/2011 with the original fax 2/16/2011. Employee #5/LPN stated, "I guess I better call the office." Employee #5/LPN received a fax from resident's primary care physician, dated 6/23/2011 at 1:31 p.m., agreeing to increase Resident #10's Lexapro per the Psychologist recommendations on 2/15/2011. The attending physician signed and dated the agreement as "2/16/11." 3.1-22(a)		**attending physician immediately and document in the resident's medical record.** **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **Recommendations from consultants, including psychologist, will be given to nursing and nursing will notify resident's attending physician of recommendations. These recommendations will be faxed to the attending physician by nursing. Return fax is expected within 24 hours, after 24 hours, if no fax/phone is received, the facility will contact the attending physician by phone. As a reminder to nursing for follow up, the original request is to be maintained with the 24 hours report sheet until request is answered by physician. The DON will inservice licensed nurses on. At least 5 days per week, the DON will review the 24 hour report, focus charting for any outstanding recommendations that have not been addressed by the physician. The DON or designee will document finding on QA form F250 5 days per week. If the DON identifies transmittal on the 24 hour report that the attending physician has not addressed within 24 hours, she will immediately**	

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			ensure the attending physician is notified. Once the attending physician has been notified, the DON will retrain the staff member(s) involved. In addition, progressive disciplinary action will be taken for continued noncompliance. **This process will continue indefinitely and on an ongoing basis.** **4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** **While the process of the DON reviews at least 5 days per week is ongoing, the documentation of the reviews will be done through the next 30 days. Once that time frame is completed, the QA &A committee will determine the continued frequency of the review documentation.** **The DON will bring the results of the QA audit to the interdisciplinary team meeting 5 days per week, the weekly Standard of Care meeting, the monthly QA&A meeting and to the quarterly QA&A meeting that is attended by the medical director for review and recommendations.** **Date of compliance July 23, 2011.**	

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F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on record review and interview, the facility failed to ensure timeliness of an initial physician visit for 1 resident in a sample of 10 who were reviewed for physician visits. (Resident #17) Finding include: Resident #17's clinical record was reviewed on 6-21-11 at 3:47 p.m. His diagnoses included, but were not limited to pneumonia, diabetes mellitus type 2, unavoidable weight loss related to progressive senile dementia, hypertension, coronary artery disease, benign prostatic hypertrophy (enlarged prostate), and depression. Resident #17 was admitted to the facility on 4-26-11. Review of the physician visits indicated his physician made an initial visit on 6-15-11. This was 50 days after the resident was admitted into the facility. On 6-22-11 at 11:30 a.m., the Director of Nursing provided a copy of a policy entitled, "Physician Visits," with an issue	F0387	**F 387 Frequency of Physician Visits** **It is the policy of this facility that residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Resident #17 was seen by the attending physician on April 24 and on April 26, 2011 at Decatur County Memorial Hospital. Resident # 17 was seen again by the attending physician April 26 and on June 15, 2011 this facility.** **The facility wishes to point out that resident #17 was seen by the attending physician at least once every 30 days as he was seen by the attending physician on April 24th, April 26th and again on June 15, 2011.**	07/23/2011

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	date of June 2004. In interview, the Director of Nursing indicated this was the current policy. The policy indicated, "New admissions and Medicare residents will be seen by their physician every 30 days for the first 90 days." 3.1-22(d)(1)		**Per federal guidelines F-tag 388, interpretive guidelines 483.40 (c): "Must be seen" means that the physician must make an actual face-to-face contact with the resident. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission."** **2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?** **No other residents were affected by this deficient practice.** **On July 7, 2011 an audit was completed on all new admissions within the last 60 days to ensure physician visits occurred timely at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter per federal guidelines and per facility policy.** **3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **The clinical nurse specialist will inservice the DON and MDS coordinator/medical records designee on the facility**	

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			policy/procedure for physician visits on July 15, 2011. **Per facility policy, the MDS/medical records designee will track physician visits to ensure residents are being seen on a timely basis. The MDS/medical records designee will notify the physicians of visits due at the beginning of each month and will keep documentation of the notifications. If the physician is continually untimely with visits, the Administrator will notify the Medical Director for assistance and guidance.** **The Administrator and/or Medical Director will send a letter to the physician requesting a visit be made for regulatory compliance.** **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** **The process of the MDS/medical record designee tracking physician visit and notifying physicians of visits due at the beginning of each month is ongoing. As stated above, if the physician is continually untimely with visits, the Administrator will notify the Medical Director for assistance/guidance. The Administrator and/or Medical Director will send a letter to the physician requesting a visit be made for regulatory compliance. This process will also be ongoing.**	

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			While the above is an ongoing process, at least five days per week, the MDS/medical records designee will review the 24 hour report to identify new admissions for the purpose of tracking physicians visits. Documentation of the reviews will be done for the next 30 days using QA audit tool F 387. Once this time frame is completed the QA&A committee will determine the continued frequency of the review documentation. **The MDS/medical records designee will bring the results of the QA audit to the interdisciplinary team meeting 5 days per week, the weekly Standard of Care meeting, the monthly QA&A meeting and to the quarterly QA&A meeting that is attended by the medical director for review and recommendations. Date of compliance :July 23, 2011.**	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record review and interview, the facility failed to ensure a resident's TB[tuberculosis] Mantoux test was read within 48 to 72 hours after administered. This affected 1 of 10 residents reviewed	F0441	**F 441 Infection Control** **It is the policy of this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable**	07/23/2011

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	for TB Mantoux testing in a sample of 10. (Resident #15) Findings include: On 6/22/2011 at 2:00 p.m., the record review of Resident #15, indicated that she was admitted with diagnoses that included, but were not limited to anxiety, pneumonia, anemia, fibromyalgia, colitis, osteoporosis, allergies, and hypertension. Review of "RECORD OF T.B. TESTS AND IMMUNIZATIONS" for Resident #15, indicated she received a Mantoux test in RFA[right forearm] on 6/8/11 administered by an LPN. The "Date Read" and "Results" columns contained no documentation. During an interview on 6/22/2011 at 2:30 p.m., with Employee #5/LPN, she stated, "No, it wasn't read, not documented any place else". "I will administer a new TB Mantoux test on Friday, so I will be here to read it myself on Monday." Employee #5/LPN indicated their policy and procedure is the same as the State guidelines: 1st step prior to or day of admission, 2nd step 2-3 weeks after the 1st step, and then annually. If a resident has had a previous reaction to the TB Mantoux test then we do a questionnaire each year to check symptoms and chest		**environment and to help prevent the development and transmission of disease and infection.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Resident #15 was administered a first step mantoux on 6/26/11 and results were read on 6/29/11. The results were "0' mm induration. Resident # 15 did not receive a second step PPD, as the resident was discharged to home on 7/3/2011.** **2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken?** **Every residents medical record shall be audited to ensure all 1st step mantoux/PPDs and 2nd step mantoux/PPDs have been administered and read per facility policy or if PPD is contra-indicated the audit will ensure that a CXR has been completed and the resident is free of active TB.** **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** **Every new admission will receive the first and second step mantoux per facility policy.**	

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	x-ray." 3.1-18(e)		**The Director of Nursing will inservice licensed nurses on the facility policy/procedure for mantoux skin test on July 15, 2011. The admitting nurse will administer the first step mantoux and will ensure the second step mantoux is added to the MAR to be administered 1-3 weeks after the first step.** **The admitting nurse for resident #15 shall receive progressive disciplinary action for her failure to follow this policy.** **This process will continue indefinitely, on an ongoing basis..** **The MDS Coordinator/medical records designee shall perform a clinical record admission audit on new admissions between 24-48 hours to ensure the first step mantoux has been administered and to ensure the second step mantoux has been added to the MAR to be administered one (1) to three (3) weeks after the first step. Once the MDS Coordinator/medical records designee has completed the clinical record admission audit the results will be forwarded to the Director of Nurse's. The results of the clinical record admission audit will be reviewed at the IDT meeting 5 days per week.** **If the MDS Coordinator/medical records designee identifies a**	

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			resident that has not received the first step mantoux or the second step mantoux has not been added to the MAR she will immediately notify the charge nurse on duty and the Director of Nurse's. **4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** **The Director of Nurse's and the MDS Coordinator will bring the results of their QA audits to the monthly QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement as needed. Any recommendations for improvement will be followed up by the Director of Nurse's who will report on the results of those recommendations at the next QA&A meeting.** **While the process of the Director of Nurse's reviews at least 5 days per week is ongoing, the documentation of their reviews will be done through the next 30 days. Once that time frame is completed, the QA&A Committee will determine the continued frequency of the review documentation.** **Date of compliance: July 23, 2011.**	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure clinical records were accurately documented in regard to advance directives, physician orders for urinary catheters and recording of urinary outputs for urinary catheters. This deficient practice affected 2 of 10 residents in a sample of 10 reviewed for accuracy of documentation of clinical records. (Residents # 5 and #28) Findings include: 1. Resident #5's clinical record was reviewed on 6-22-11 at 10:25 a.m. His diagnoses included, but were not limited to diabetes mellitus type 2, hypertension, benign prostatic hypertrophy (enlarged prostate), congestive heart failure, deep vein thrombosis and pulmonary embolism (blood clots in the legs and lungs), chronic urinary retention, mild dementia, depression and chronic pain. The clinical	F0514	**F 514 Clinical Records It is the policy of this facility to maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. F514-1.a 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #15's attending physician was notified for order clarification of the code status. The order clarification was faxed to the pharmacy so that the monthly physician's orders can be updated to included the order clarification. 2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? The Medical Records Coordinator and Social**	07/23/2011

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	record indicated he had utilized a urinary catheter for several years due to urinary retention. The resident was admitted to the facility on 12-1-10. a. Review of Resident #5's advanced directive form, entitled, "Resuscitation Status Form," indicated his POA (Power of Attorney) had indicated she desired for the resident to be resuscitated in the event that he stopped breathing or his heart stopped beating. This form was undated. A handwritten notation indicated the resident had been a no-code status on his physician's office chart. It indicated the facility had spoken with the POA and she desired him to be a full code. It indicated the physician would be at the facility on 12-15-10. Review of Resident #5's recapitulation orders for June 2011 indicated the resident was listed as "No Code," with an effective date for this listed as 12-16-10. Review of an interdisciplinary care plan indicated the resident's desire to be resuscitated in the event he stopped breathing or his heart stopped beating. This care plan had an initial date of 12-1-10, with review dates of 3-10-11 and 6-10-11 indicated. Review of physician progress notes		**Services Director shall audit every resident's medical record to ensure the resuscitation status form, advanced directive, monthly physician orders (rewrites), sticker on the residents door frame and sticker on the residents medical record are accurate. If any discrepancies are identified the Director of Nursing shall be notified immediately and she will notify the MD and residents legal representative for code status clarification and document in the medical record and ensure the resuscitation form monthly physician orders, sticker on the resident's door frame and sticker on the resident's medical record are accurate. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? On admission of new resident's the Director of Nursing and the Social Services manager shall obtain in writing the resident's and/or legal representative designation of the resident's code status. A list of residents having a "full code" status shall be maintained at the nurse's station and will be checked weekly by the Director of Nurses to ensure it is current. The Director of**	

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	indicated the physician had noted on 1-21-11 and 6-10-11 that the POA desired for the resident to be a "Full Code." In interview with the Director of Nursing (DON) on 6-22-11 at 11:10 a.m., she indicated she was unaware of the recapitulation orders listing Resident #5 as a "no code." She indicated his care plan and the advanced directive indicated he was to be a full code. b. Review of Resident #5's recapitulation orders for June 2011 indicated, "Change F/C (Foley catheter/urinary catheter) monthly." This entry had an effective date listed as 12-16-10. In interview with the DON on 6-22-11 at 2:05 p.m., she indicated the facility's policy regarding urinary catheters, "says orders should include a catheter size." On 6-22-11 at 11:30 a.m., the DON provided a copy of a policy entitled, "Catheterization -- Indwelling," with an issue date of June 2004. The policy indicated, "Check physician order. It must include catheter size, balloon size, frequency of change, special catheter care and irrigation if required." c. Review of Resident #5's urinary output records indicated the urinary output		**Nurses, Social Services Manager and licensed nurses shall be inserviced on ensuring the resuscitation status form, month physician order, sticker on the resident's door frame and sticker on the resident's medical record are accurate. The MDS/medical records designee will continue to complete new admission audits 24-48 hours after admission to the facility. Once the MDS/medical records designee has completed the new admission audits they will be forwarded to the Director of Nurses for follow-up as needed. On a quarterly basis, the care plan team will continue to review the residents' code status as part of the care plan conference. Any changes to the code status of a resident will be followed up by the DON at that time to ensure the new code designations have received the appropriate colored sticker designation. All newly hired nursing staff will continue to receive orientation to the system for identifying residents code status, as well as the facility policy regarding their response to finding a unresponsive resident. 4. How will corrective action be monitored to ensure the deficient practice does not**	

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	documentation was not routinely recorded on the facility's intake and output records. Review of the March 2011 output record indicated 20 of 93 shift totals were absent. Review of the April 2011 output record indicated the dates of April 1 through 28 were documented with 14 of 84 shift totals were absent, with the additional dates of April 29 and 30 not present. Review of the May 2011 output record indicated 28 of 93 shift totals were absent. In interview with the DON on 6-22-11 at 2:05 p.m., she indicated, "The nurses are to make sure the I&O's (intakes and outputs) are charted each shift." She indicated the I&O's do not have to be charted on the treatment record as there is a record to document this information. On 6-22-11 at 11:30 a.m., the DON provided a copy of a policy entitled, "Intake and Output Measurement," with an issue date of June 2004. This policy indicated all residents with an indwelling catheter requires "measurement and documentation of intake and output every eight hours, including a 24 hour total." 2. Resident #28's clinical record was reviewed on 6-20-11 at 9:20 a.m. His diagnoses included, but were not limited to acute myocardial infarct (recent heart attack), dementia, cerebrovascular		**recur and what QA will be put into place? The Director of Nurse, Social Services Manager or MDS/medial records designee will review at least 3 resident's medical records at least 5 days per week to ensure the resuscitation form, monthly physician orders, care plan and sticker on the residents door frame and sticker on the resident's medical record have the correct and appropriate code designation. Results of the medical record review will be documented on the QA audit form F 514-a. The QA audit form will be brought to the monthly QA Committee meeting for review and recommendations. The committee will review the results and provide recommendations for process improvement as needed. Any recommendations for improvement will be followed up by the Director of Nurse's who will report on the results of those recommendations at the next QA&A meeting. The documentation of their reviews will be done through the next 30 days. Once that time frame is completed, the QA&A Committee will determine the continued frequency of the review documentation. Date of Compliance: July 23, 2011. F**	

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	accident (stroke), diabetes type 2, coronary artery disease, schizophrenia, depression, anxiety and restless leg syndrome. He was admitted into the facility on 7-21-09. Review of Resident #28's clinical record indicated an absence of information of his advance directive status (code status) on the June 2011 recapitulation orders. Review of the Social Services progress notes indicated an entry, dated 5-20-11, "his code status is DNR (do not resuscitate.)" In interview with the DON on 6-21-11 at 10:20 a.m., she indicated the code status should be on the recapitulation orders and are usually found at the beginning of those orders. She indicated she did not find that information on Resident #28's recapitulation orders. 3.1-50(a)(1) 3.1-50(a)(2)		**514-1.b 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On June 22, 2010 resident #5's foley catheter orders were clarified to include the catheter and balloon size. 2. How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken? No other resident was affected by this practice. Two (2) residents with foley catheterrs reside in the facility at this time. Resident # 5's orders for foley catheter have been clarified to include the size of the catheter and the balloon. The other resident with a foley catheter residing in the facility has had orders for foley catheter reviewed, and the size of the catheter and balloon were present. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The licensed nurses shall be inserviced on the facility policy and procedure for "Catheterization-Indwelling", including physician orders for catheter that include catheter size, balloon size, frequency of change, special catheter care**	

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			and irrigation if required on July 15, 2011. In addition to the above, at least 5 days per week, the DON or designee will review the 24 hour report and focus charting for any new orders for catheters-indwelling. The DON or designee will review the new orders and ensure the new order includes the catheter size, balloon size, frequency of change, special catheter care and irrigation if required and indications for use. If the Director of Nurse's identifies orders for catheter use that do not include the catheter size, balloon size, frequency of change, special catheter care and irrigation if required and indications for use the Director of Nurses will notify the attending physician immediately for order clarifications and document in the medical record. Once the resident is taken care of the Director of Nurses will re-train staff involved. In addition, progressive disciplinary action will be taken for continued noncompliance. The Director of Nurses shall document findings on QA Audit form F-514-1.b, 5 days per week. This process will continue indefinitely and on an ongoing basis. 4. How will corrective action be monitored to ensure the deficient practice does not	

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			recur and what QA will be put into place? While the process of the DON reviewing the 24 hour reports and focus charting at least 5 days per week is ongoing, the documentation of the reviews will be done through the next 30 days. Once that time frame is completed, the QA &A committee will determine the continued frequency of the review documentation. The DON will bring the results of the QA audits to the interdisciplinary team meeting 5 days per week, the weekly Standard of Care meeting, the monthly QA&A meeting and to the quarterly QA&A meeting that is attended by the medical director for review and recommendations. Date of Compliance: July 23, 2011. F514-1.c. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Per facility policy for Intake and Output Measurement all residents with indwelling catheters shall have measurement and documentation of intake and output every eight (8) hours, including a 24-hour total. 2. How other residents having the potential to be affected by the same practice will be identified and what corrective	

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			action(s) will be taken? Every residents medical record shall be audited to identify residents that per facility shall have intake and output measured and documented. Residents identified as having indwelling catheters, receiving enteral nurtitional therapy, receiving intravenous feeding, including TPN, with specific physician's orders for measurements of intake and output, an order or fluid restriction or encouragement shall have intake and output measurement per facility policy. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Director of Nursing will inservice both licensed and non-licensed nursing staff on the facility policy and procedure for "Intake and Output Measurement". The Dietary Manager or designee will audit the Fluid & Meal Percentage Intake Log at least 5 days per week to ensure intake has been recorded for the previous day. The charge nurse will audit intake & output measurement logs every shift to ensure the output has been recorded before the end of his/her shift. The Director of Nurses shall review the intake	

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			& output measurement logs at least 5 days per week to ensure tboth the intake and output have been recorded for the previous day. The Director of Nurses shall document findings on QA Audit form F-514-1.c, 5 days per week. This process will continue indefinitely and on an ongoing basis. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Date of Compliance: July 23, 2011. F 514-2 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The attending physician and resident legal representative will be contacted for clarification of code status. Once the attending physician clarifies the residents code status the order shall be written and faxed to the pharmacy to ensure the code status appears correctly on the monthly physician orders. In addition to the above the legal representative and attending physician shall sign the "Resuscitation Status Form" designating code status. 2. How other residents having the potential to be affected by the same practice will be	

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			identified and what corrective action(s) will be taken? The Medical Records Coordinator and Social Services Director shall audit every resident's medical record to ensure the resuscitation status form, advanced directive, monthly physician orders (rewrites), sticker on the residents door frame and sticker on the residents medical record are accurate. If any discrepancies are identified the Director of Nursing shall be notified immediately and she will notify the MD and residents legal representative for code status clarification, document in the medical record and ensure the resuscitation form, monthly physician orders, sticker on the resident's door frame and sticker on the resident's medical record are accurate. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? On admission of new resident's the Director of Nursing and the Social Services manager shall obtain in writing the resident's and/or legal representative designation of the resident's code status. A list of residents having a "full code" status shall be maintained at the nurse's station and will be	

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			checked weekly by the Director of Nurses to ensure it is current. The Director of Nurses, Social Services Manager and licensed nurses shall be inserviced on ensuring the resuscitation status form, month physician order, sticker on the resident's door frame and sticker on the resident's medical record are accurate. The MDS/medical records designee will continue to complete new admission audits 24-48 hours after admission to the facility. Once the MDS/medical records designee has completed the new admission audits they will be forwarded to the Director of Nurses for follow-up as needed. On a quarterly basis, the care plan team will continue to review the residents' code status as part of the care plan conference. Any changes to the code status of a resident will be followed up by the DON at that time to ensure the new code designations have received the appropriate colored sticker designation. All newly hired nursing staff will continue to receive orientation to the system for identifying residents code status, as well as the facility policy regarding their response to finding a unresponsive resident. 4. How	

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			will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Director of Nurse, Social Services Manager or MDS/medial records designee will review at least 3 resident's medical records at least 5 days per week to ensure the resuscitation form, monthly physician orders, care plan and sticker on the residents door frame and sticker on the resident's medical record have the correct and appropriate code designation. Results of the medical record review will be documented on the QA audit form F 514-a. The QA audit form will be brought to the monthly QA Committee meeting for review and recommendations. The committee will review the results and provide recommendations for process improvement as needed. Any recommendations for improvement will be followed up by the Director of Nurse's who will report on the results of those recommendations at the next QA&A meeting. The documentation of their reviews will be done through the next 30 days. Once that time frame is completed, the QA&A Committee will determine the	

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			continued frequency of the review documentation. Date of Compliance: July 23, 2011.	